



**BlueCross BlueShield
of Florida**

An Independent Licensee of the
Blue Cross and Blue Shield Association

Flexible Spending Account Annual Expense Worksheet

Estimated Annual Expenses

Estimating your annual out-of-pocket health care and dependent care expenses will help you to determine your contribution amount(s).

Please **refer to your enrollment material** to determine the **Health Care** Flexible Spending Account (FSA) maximum amount that you can contribute to your Health Care FSA. For **Dependent Care (Daycare)** FSA, you may elect any amount up to an annual maximum of \$5,000 per family (if you are head of household or married and file a joint tax return) or \$2,500 (if you are married and file a separate tax return). *

Your employer may provide a contribution to either the Health Care FSA or your Dependent Care FSA (not both). If your employer is contributing to either FSA, this amount must be subtracted from the annual maximum allowed for either account.

Health Care Flexible Spending Account		Dependent Care (Daycare) Flexible Spending Account	
Please refer to the enrollment material for 1) a summary list of qualified medical expenses eligible under your employer's plan and 2) a definition of eligible dependent(s) for whose expenses may be reimbursable under your employer's plan. For a full description of the FSA plan, refer to your employer-provided summary plan description.		You can use the Dependent Care FSA to help pay your expenses for nursery school or daycare for younger children, disabled older children, a spouse, an elderly parent or a disabled parent who lives with you full-time. Each person must meet the definition of a "qualifying" child or dependent under the IRS Child and Dependent Care Credit guidelines [i.e., an eligible child must be under age 13 (unless disabled and has less than \$3,000 gross income) when care was provided and claimed as a dependent on your tax return].	
Annual medical expenses, such as:		Annual dependent daycare expenses for:	
Deductibles, coinsurance and copayments	\$ _____	Day Care Center(s) for Child Care	\$ _____
Routine physical exams	\$ _____	In-home Care for Child Care	\$ _____
Well-baby care	\$ _____	Nursery and Pre-school	\$ _____
Hearing exams, hearing aids	\$ _____	After School Care	\$ _____
Prescriptions drugs	\$ _____	Au Pair Services	\$ _____
Other eligible expenses	\$ _____	Summer Day Camps	\$ _____
Dental expenses, such as:		Day Care Center For Elder Care	\$ _____
Gold fillings, crowns, fixed bridge or other restorative expenses	\$ _____	In-home Care for Elder Care	\$ _____
Treatment exceeding your plan's limits	\$ _____	Estimated Annual Expenses Subtotal	\$ _____
Vision care expenses, such as:		Minus Employer Contribution (if any)	(_____)
Exams	\$ _____		
Eyeglasses, contact lenses	\$ _____		
Other estimated health-related expenses which may exceed your plan's limits:	\$ _____	Estimated Dependent Care FSA Contribution	\$
Outpatient psychiatric care	\$ _____	This is the estimated amount you may want to contribute to your Dependent Care FSA. This amount cannot exceed the annual Dependent Care FSA maximum amount.	
Therapy	\$ _____		
Estimated Annual Expenses Subtotal	\$ _____		
Minus Employer Contribution (if any)	(_____)		
Estimated Health Care FSA Contribution			
This is the estimated amount you may want to contribute to your health care FSA. This amount cannot exceed the annual Health Care FSA maximum amount.			

* Special lower limits exist for spouses who are full-time students. Please contact your benefits representative for guidance.